EMS Reciprocity/Challenge Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Send completed application and other documents to:

Department of Health
EMS Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Instructions Checklist

Important background check information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigations (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the required forms.

Initial EMS certification applicants must provide a copy of a course completion certificate/letter from a Department of Health approved EMS Training Program and the National Registry examination results for the certification level they are applying for.

Check Appropriate Box: Reciprocity or Challenge

- **Reciprocity:** Applying for Washington State EMS Provider certification based on current EMS provider certification from another state or with the National Registry of Emergency Medical Technicians. See the reciprocity requirements in the "Additional Information" below.
- **Challenge:** Applying for certification based on possession of a current health care provider credential and proof of education equivalent to the knowledge and skills for the level of certification. See the challenge requirements in the "Additional Information" below.

☐ **1. Demographic Information:**

Social Security Number: You **must** list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form. your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state, and country you were born in.

Address: List the address we should use to send any information about your credential. Be sure to include the city, state, zip code, county, and country. This will be your permanent record with Department of Health until we have been notified of a change. See **WAC 246-976-144 (6)** or **WAC 246-976-171 (6)**.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include legal proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. These are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the questions. If you do not provide the documents, your application is incomplete and will not be processed.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can obtain copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Education:**
Provide education and training information as requested and provide required documents.

☐ **4. Previous or Additional Credentials:**
List all states, including Washington, where health care provider credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. Attach additional completed pages if you need more space.

☐ **5. AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in **WAC 246-12-270**.

☐ **6. Applicant's Attestation:**
You must print your name and read the statement thoroughly to ensure you understand the provisions in this section. Provide the date and city you are in, then sign the statement. This must be complete in order for us to process your application.

☐ **7. Applicant's Proof of Identity:**
Attach to the application a current, legible photograph showing date of birth (DOB) ie., drivers's license photo, passport, or military ID. The photograph must be clear and the information must be legible.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

Additional Information:

Reciprocity: The following are required with your application:

Proof of valid EMS certification from another state or national certifying agency approved by the department.

- Paramedic applicants: proof of successful completion of a paramedic program. Submit a copy of a course completion certificate, letter, or transcripts from the paramedic training program. Applicants completing training after June 30, 1996, must have completed a paramedic program accredited by a national accrediting organization approved by the department.
- Accredited programs may be found at **http://www.caahep.org/**

Applicants must have passed a Department of Health approved certification examination for the level of certification. The score is valid for twelve months from the date of the examination. After twelve months, a passing score on a department-approved certification examination is required. Applicants will have three attempts within twelve months from the first examination date to pass the examination. After three unsuccessful attempts or twelve months, the applicant must complete an approved initial EMS course to reapply for certification.

Challenge: The following are required with your application:

Course completion documents showing education equivalent to the knowledge and skills at the EMR, EMT, or AEMT training level. Once your documents have been reviewed you will be notified of the appropriate examination needed.

- Applicants seeking paramedic certification - successful completion of a paramedic course through a training program accredited by a department-approved national accrediting organization.

Provide proof of a valid health care provider credential.

Applicants must have passed a Department of Health approved certification examination for the level of certification. Applicants will have three attempts within twelve months from the first examination date to pass the examination. After three unsuccessful attempts or twelve months, the applicant must complete an approved initial EMS course to reapply for certification.

A completed EMS application consists of the following:

- EMS Reciprocity/Challenge Application
- EMS Supervisor/Medical Program Director Signature Form
- Certificate of Course Completion
- EMS Verification Form

Information regarding the EMS Program is available on our **Web Site**.

Note: You cannot practice as emergency medical services provider until your certification is issued.

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Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

EMS Reciprocity/Challenge Application

Check Appropriate Box: ☐ Reciprocity ☐ Challenge

Certification Level (check one): ☐ EMR ☐ EMT ☐ AEMT ☐ Paramedic

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)

Name ☐ Male ☐ Female First Middle Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address (if different from above)

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

For Office Use Only

Credential # _____ Issue Date _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ..... ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ..... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ..... ☐ ☐

   b. Diverted controlled substances or legend drugs? ..... ☐ ☐
   c. Violated any drug law? ..... ☐ ☐
   d. Prescribed controlled substances for yourself? ..... ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? . ..... ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ..... ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ..... ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ..... ☐ ☐

3. Education

1. Will you be primarily "paid" or "volunteer" EMS provider? ..... ☐ Paid ☐ Volunteer
2. Have you earned a high school diploma or GED certificate? ..... ☐ Yes ☐ No
   (EMR exempt)
3. Are you active duty military or deployed? ..... ☐ Yes ☐ No

4. Previous or Additional Credentials

List all states, including Washington, in which you hold or have held a health care license, certification, or registration.

State	Profession	License Type	License		Method of License	Currently in Force
			YR issued	Number		
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

5. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand I should provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

6. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of the state
(Name of Applicant)

of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and RCW **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of Applicant)

7. Applicant's Proof of Identity

Attach a copy of your official state or federal photo identification, such as military identification, drivers license or passport.

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Washington State Department of Health
EMS Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

EMS Verification Form

Please make copies if necessary, and complete the top portion (please print) and send to all state(s) where current EMS certifications or licenses are held. Please note that some states may charge a fee to complete this form.

Name: _____
(Last name, First name, MI)

Also known as: _____

Mailing address: _____
(Address, City, State, Zip Code)

Washington State Where you will be working or volunteering: _____

I hereby authorize the (state in which you are currently certified/licensed)_____
EMS agency to furnish the information requested on this document.

Certification/license number:_____EMS level/type: _____

Social Security Number: _____ Date of birth:_____
(mm/dd/yyyy)

Status of EMS certification/license:

EMS level/type of certification: _____

☐ Active certification/license no: Expiration Date _____
(mm/dd/yyyy)

☐ Inactive

Applicant received certification/license by: Exam .....☐ Yes ☐ No

Reciprocity granted on certification from _____
(State, national registry)

Has this person ever been disciplined, been placed on probation or had their certification/license suspended, revoked or denied by your agency, or by the supervising physician?.....☐ Yes ☐ No

I hereby certify that the above is true and correct as recorded in the files of this office.

_____ Signature

_____ Name (print)

_____ Title

_____ Date

_____ Agency name

_____ State

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General Instructions Checklist EMS Supervisor/Medical Program Director Signature Form

The EMS Supervisor/Medical Program Director Signature form is required for each of the following applications:

- Initial EMS Certification Application
- EMS Out-of-State Reciprocity/Challenge Application
- Recertification Application

☐ **1. Identification Information:**

Fill in your Department of Health credential number, telephone number, date of birth, name, and address. Your credential number can be found at **Provider Credential Search**.

☐ **2. EMS Agency Assocation Requirement and EMS Supervisor:**

In order to be certified you must be associated with an EMS agency licensed by the Washington State Department of Health. Your EMS agency supervisor must complete this portion of the form.

Note: You cannot sign for yourself as supervisor. Please have your supervisor sign and date the form.

☐ **3. County Medical Program Director (MPD):**

Follow the instructions from your local EMS coordinator or EMS agency supervisor to obtain your MPD's recommendation, signature and date. Your application is not complete until it is signed and dated by the MPD recommending you for certification.

Additional Information:

The EMS application process requires both this signature form and the appropriate Certification Application Packet.

Washington State Department of Health

EMS Supervisor/Medical Program Director Signature Form

Check Appropriate Box:

☐ Initial ☐ Upgrade ☐ Reversion ☐ Reciprocity ☐ Challenge

☐ Recertification ☐ Reissuance ☐ Reinstatement

Certification Level (check one): ☐ EMR ☐ EMT ☐ AEMT ☐ Paramedic ☐ Poison Information Specialist

1. Identification Information

Department of Health Credential Number

Name First Middle Last

Birthdate (mm/dd/yyyy)	Phone (enter 10 digit #)	Email Address:

Address

City	State	Zip Code	County

2. EMS Agency Association Requirement and EMS Supervisor

Please provide the following information regarding your primary agency association:

Agency Name and Number: _____

Address: _____

Phone (enter 10 digit #): _____

EMS Contact Person: _____

EMS Contact Email: _____

"I affirm that if this applicant is certified, he/she will provide care with our EMS agency."

Printed Name of EMS Agency Supervisor	Original Signature	Date

3. County Medical Program Director (MPD)

The signature of the Washington State Medical Program Director (MPD) for the county where the applicant is providing care, or where his/her EMS agency is based, is required before state certification may be granted to this applicant.

☐ "I recommend certification of this applicant based on the statements above, and the successful completion of the required examinations and/or evaluations. This applicant, if recommended for certification, has a copy of my county protocols."

Protocol requirements do not apply to poison information specialists.

☐ I do not recommend certification (attach a memo for details)

Printed Name of County MPD	Original Signature	Date

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act..... RCW 18.130

Administrative Procedure Act .....RCW 34.05

Emergency Medical Services and Trauma System RCW .....RCW 18.71

Emergency Medical Services and Trauma System RCW .....RCW 18.73

Emergency Medical Services and Trauma System WAC..... WAC 246-976

On-Line

Emergency Medical Services and Trauma System.....Web Page